

# State Health Plan

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# Your State Health Plan in 2006

The State Health Plan, which includes the **Standard Plan** and the **Savings Plan**, provides you and your family with valuable medical coverage when you are sick or injured. With the plan, you have extensive coverage when you need it most.

The State Health Plan is self-insured. This means the Employee Insurance Program (EIP) determines the plan's coverage and benefits. EIP does not pay premiums to an insurance company. Your monthly premium, combined with all other premiums and your employer's contribution, is placed in a trust account maintained by the state to pay claims and administrative costs. Any interest earned on this trust account is used to help fund the plan.

In 2006, the State Health Plan is expected to pay more than one billion dollars in claims for its subscribers. EIP contracts with companies, such as BlueCross BlueShield of South Carolina, to process medical claims; APS Healthcare, Inc., to process mental health and substance abuse claims; and Medco, to process prescription drug claims. About three percent of our budget goes to pay these claims processors.

To learn about enrollment, eligibility and other features that are common to this health program and others offered by EIP, see the General Information chapter beginning on page 7. The chapter you are now reading will help you understand the different requirements and benefits of the Standard Plan and the Savings Plan. It also discusses the features they share. Check the Premiums chapter on page 167 to learn about the rates for each plan.

The *Plan of Benefits* document contains a complete description of the plan. Its terms and conditions govern all health benefits offered by the state. If you would like to review this document, contact your benefits administrator or EIP.

## Your State Health Plan at a Glance

The State Health Plan offers two choices: the **Standard Plan** and the **Savings Plan**. Regardless of which plan you choose, it is important that you understand how your plan works.

The Standard Plan has higher premiums but lower deductibles than the Savings Plan. When one family member meets his deductible, the Standard Plan will begin to pay benefits for him, even if the family deductible has not been met. Under the Standard Plan, you make a copayment, rather than pay the full allowable cost, when you buy a prescription drug. You do not have to meet your deductible to receive the prescription drug benefit.

The Savings Plan was new in 2005. If you are willing to take greater responsibility for your healthcare costs and accept a higher annual deductible, you can save money on premiums. Because it is a tax-qualified, high-deductible health plan, eligible subscribers who enroll in the Savings Plan and who have *no other health coverage, including Medicare*, unless it is another high deductible health plan, may establish a Health Savings Account. Funds in this account may be used to pay qualified medical expenses now and in the future.

## How SHP Benefits are Paid

State Health Plan subscribers share the cost of their covered benefits by paying deductibles and coinsurance for medical and behavioral health services. Standard Plan subscribers also pay per-occurrence deductibles and copayments for prescription drugs. This is how you help keep premiums low and preserve benefits.

# Benefits at a Glance

This brief overview of your medical plan is for comparison purposes only. The *Plan of Benefits* document governs all health benefits offered by the state.

	Standard Plan	Savings Plan
<b>Annual Deductible</b>	\$350 Individual \$700 Family	\$3,000 Individual \$6,000 Family (If more than one family member is covered, no family member will receive benefits, other than preventive, until the \$6,000 annual family deductible is met.)
<b>Per-occurrence Deductibles:</b>		
Emergency Care <sup>1</sup>	\$125	None
Outpatient Hospital <sup>2</sup>	\$75	None
Outpatient Office Visit <sup>3</sup>	\$10	None
<b>Coinsurance:</b>		
Network	20% You Pay 80% State Pays	20% You Pay 80% State Pays
Out-of-network <sup>4</sup>	40% You Pay 60% State Pays	40% You Pay 60% State Pays
<b>Coinsurance Maximum:</b>		
Network	\$2,000 Individual \$4,000 Family	\$2,000 Individual \$4,000 Family
Out-of-network	\$4,000 Individual \$8,000 Family	\$4,000 Individual \$8,000 Family
<b>Lifetime Maximum</b>	\$1,000,000	\$1,000,000
<b>Prescription Drug Deductible per Year</b>	No Annual Deductible	You pay the full allowable cost for prescription drugs, and the cost is applied to your annual deductible.
<b>Retail Copayments for up to a 31-day supply</b> (Participating pharmacies only)	\$10 Generic \$25 Preferred Brand \$40 Non-preferred Brand	After you reach your deductible, you continue to pay the full allowable cost for prescription drugs. However, the plan will reimburse you for 80% of the allowable cost of your prescription. You pay the remaining 20% as coinsurance.
<b>Mail Order Copayments for up to a 90-day supply</b>	\$25 Generic \$62 Preferred Brand \$100 Non-preferred Brand	
<b>Prescription Drug Copayment Maximum</b>	\$2,500 per person (applies to prescription drugs only)	You must use participating pharmacies. Drug costs are applied to your plan's in-network coinsurance maximum: \$2,000 - individual; \$4,000 - family. After the coinsurance maximum is met, the plan pays 100% of allowable costs.
<b>Tax-favored Medical Accounts</b>	Medical Spending Account	Health Savings Account Limited-use Medical Spending Account

<sup>1</sup>Waived if admitted.

<sup>2</sup>Waived for dialysis, routine mammograms, routine pap smears, clinic visits, ER, oncology, electro-convulsive therapy, psychiatric medication management and physical therapy visits.

<sup>3</sup>Waived for routine Pap smear, routine mammograms and Well Child Care.

<sup>4</sup>There are no out-of-network benefits for mental health and substance abuse services or prescription drugs.

## HOW THE STANDARD PLAN WORKS

### Annual Deductible

The annual deductible is the amount of covered expenses (including mental health and substance abuse expenses) you must pay each year before the plan begins to pay benefits. The annual deductibles are:

- \$350 for individual coverage
- \$700 for family coverage

Under the Standard Plan, the family deductible is the same, regardless of how many family members are covered. If you have the Standard Plan employee-only coverage, once you pay the \$350 deductible, you will begin receiving benefits. However, if you have the Standard Plan family coverage, once any one person has paid the \$350 individual deductible, he will begin receiving benefits. No one family member may pay more than \$350 toward the \$700 family deductible.

Before other family members begin receiving benefits, their individual \$350 deductible, the \$700 family deductible or a combination of individual deductibles totaling \$700 must be met. For example, if seven people each have \$100 in covered expenses, the family deductible has been met, even if no one person has met the \$350 individual deductible. If the employee and his spouse, who is also covered as an employee or retiree, wish to share the same plan family deductible, both spouses must select the same health plan.

If you are covered under the Standard Plan, you pay copayments for drugs, up to a maximum of \$2,500. Your drug costs do not apply to your deductible.

### Per-occurrence Deductible

A per-occurrence deductible is the amount you must pay before the Standard Plan begins to pay benefits each time you receive services in a professional provider's office, visit an emergency room or receive outpatient hospital services. It does not apply to your annual deductible or to your out-of-pocket maximum.

The deductible for each visit to a professional provider's office is \$10. This deductible is waived for routine Pap tests, routine mammograms and well child care visits. Here is an example of how it works:

- If the SHP Standard Plan allowed \$49 for a physician's visit, you would first pay the \$10 per-occurrence deductible. Then, if you have not met your annual deductible, the remaining \$39 would apply toward your annual deductible. (Your total bill would be \$49.)
- If you have met your annual deductible, the Standard Plan would pay 80 percent of the \$39, or \$31.20, and you would be responsible for the remaining \$7.80. (Your total bill would be \$17.80.)

The deductible for each emergency room visit is \$125. This deductible is waived if you are admitted to the hospital. The deductible for each outpatient hospital service is \$75. This deductible is waived for dialysis, routine mammograms, routine Pap tests, clinic visits (an office visit at an outpatient facility), and emergency room, oncology, electro-convulsive therapy, psychiatric medication management and physical therapy visits. Remember that outpatient facility services for psychiatric diagnoses must be provided at an APS Healthcare network facility to be covered, and that hospital visits for mental health services are not covered.

### Coinurance

After your annual deductible has been met, the Standard Plan pays 80 percent of your covered medical, mental health and substance abuse expenses if you use network providers. You pay the remaining 20 percent. If you use non-network providers, the plan pays 60 percent of your covered expenses. You pay the remaining 40 percent. This is applied to your coinsurance maximum. Even after you meet your annual deductible under the Standard Plan, you must continue to pay per-occurrence deductibles, and they do not apply to your coinsurance maximum. Mental health and substance abuse benefits are paid only if you use network providers.

A different coinsurance rate applies for infertility treatments and prescription drugs associated with infertility, see page 34.

If you use a provider outside the SHP network, you must pay any charge above the plan's allowable amount for a covered medical expense. You also will have to pay an additional 20 percent in coinsurance. See page 29 to learn more about this "out-of-network differential." If you use a non-network provider for prescription drugs or mental health or substance abuse services, no benefits will be paid.

### Coinsurance Maximum

The maximum coinsurance you must pay each year under the Standard Plan is \$2,000 for individual coverage or \$4,000 for family coverage for network services and \$4,000 for individual coverage and \$8,000 for family coverage for non-network services. The State Health Plan will then pay 100 percent of the allowable expenses.

Expenses you pay for non-covered services, prescription drugs, per-occurrence and annual deductibles, or penalties for not calling Medi-Call or APS Healthcare do not count toward your coinsurance maximum.

**What does it mean when a provider does not participate in the network?**

**For information on providers who do not participate in the network and the "out-of-network differential," see page 29.**

## HOW THE SAVINGS PLAN WORKS

### Annual Deductible

The annual deductible is the amount of covered expenses (including prescriptions drugs and mental health and substance abuse expenses) you must pay each year before the Savings Plan begins to pay benefits. The annual deductibles are:

- \$3,000 for individual coverage
- \$6,000 for family coverage

**There is no individual deductible if more than one family member is covered. The family deductible is not considered met for any individual covered until total covered medical expenses exceed \$6,000.** For example, even if one family member has \$3,001 in covered medical expenses, he will not begin receiving benefits until his family has \$6,000 in covered expenses. However, if the subscriber has \$1,000 in expenses, the spouse has \$3,001 in expenses and another child has \$2,000 in expenses, all family members will begin to receive benefits.

If you are covered under the Savings Plan, you pay the full allowable cost for covered prescription drugs, and the cost is applied to your deductible, or, if the deductible has been met, you receive reimbursement for 80 percent of the allowable cost, and 100 percent of your coinsurance maximum has been met.

There are **no** per-occurrence deductibles under the Savings Plan. You pay the full allowable cost for services, and it is applied to your annual deductible.

### Coinsurance

After your annual deductible has been met, the Savings Plan pays 80 percent of your covered medical, prescription drug, mental health and substance abuse expenses if you use network providers. You pay the remaining 20 percent. The amount you pay to network providers contributes to your coinsurance maximum. If you use non-network providers, the plan pays 60 percent of your covered expenses. You pay the remaining 40 percent.

A different coinsurance rate applies for infertility treatments and prescription drugs associated with infertility, see page 34.

If you use a non-network provider, any charge above the plan's allowable amount for a covered medical expense is your responsibility. You will also have to pay the additional 20 percent in coinsurance, a total of 40 percent. See page 29 to learn more about this "out-of-network differential." If you use a non-network provider for prescription drugs or mental health or substance abuse services, no benefits will be paid.

## Coinsurance Maximum

The maximum amount you must pay each year in coinsurance for network services under the Savings Plan is \$2,000 for individual coverage and \$4,000 for employee/spouse, employee/children and full-family coverage. The State Health Plan will then pay 100 percent of the allowable cost of your covered expenses. This limit does not include expenses for non-covered services, the annual deductible or penalties for not calling Medi-Call or APS Healthcare. If you use non-network providers, the limit on the coinsurance you must pay is \$4,000 for individuals and \$8,000 for families.

## LIFETIME MAXIMUM

The maximum amount the State Health Plan will pay for each person for all benefits is \$1,000,000. This lifetime maximum includes all payments made for a person while covered under any State Health Plan option, including the Savings, Standard and Medicare Supplemental plans and the Economy Plan, which is no longer offered. It applies regardless of any break in coverage or whether the person is enrolled in one of the plans as a dependent, an employee or a retiree.

## Coordination of Benefits

All State Health Plan benefits, including retail prescription drug and mental health benefits, are subject to coordination of benefits (COB). COB is a system to make sure a person covered under more than one insurance plan is not reimbursed more than once for the same expenses.

For more information about COB, including how plan administrators determine which plan pays first, see page 15.

Here are some specific features of coordination of benefits under the Standard Plan and the Savings Plan:

On your Notice of Election form, you are asked if you are covered by more than one group insurance plan. Your response is recorded and is placed in your file. However, the plan administrator, BlueCross BlueShield of South Carolina, may ask you this question every year, by sending you a questionnaire. Please complete this form and return it to BCBSSC in a timely manner, since claims may be held for final disposition until your information is received.

This is how the SHP works when it is secondary insurance:

- The SHP will pay the lesser of: 1) what it would pay if it were the primary payer; or 2) the part of the covered charge not paid by the primary payer.
- When the SHP is the secondary payer, the plan's limit on balance billing does not apply. This means if the provider charges more than the plan's allowance, you will be responsible for these extra charges. You will also be responsible for your copayments and for your deductible, if it has not been satisfied.
- If the SHP is the secondary payer for a medical claim, you or your provider must file the Explanation of Benefits from your primary plan directly with BlueCross BlueShield of South Carolina.
- If the SHP is the secondary payer for mental health and substance abuse benefits, you must file the Explanations of Benefits from your primary plan directly with APS Healthcare, Inc.

**If the SHP is your secondary coverage and you have an EZ REIMBURSE® Card, see page 124 for more information.**

If the SHP is the secondary payer for prescription drug benefits, when you visit the pharmacy, you should present the card for your primary coverage first. If you present your SHP card first, the claim will be rejected because the pharmacist's electronic system will indicate that the SHP is secondary coverage. After the pharmacy processes the claim with your primary coverage, you must file a paper claim through Medco for any secondary benefits to be paid. Prescription drug claim forms are available on the EIP Web site at [www.eip.sc.gov](http://www.eip.sc.gov). Choose your category, and then click on "Forms."

*Please remember:* The SHP is not responsible for filing or processing claims for a subscriber through another health insurance plan. That is your responsibility.

## Subrogation

To the extent provided by South Carolina law, the State Health Plan has the right to recover damages in full for benefits provided to a covered person under the terms of the Plan when the injury or illness occurs through the act or omission of another person, firm, corporation, or organization. If, however, a covered person receives payment for such medical expenses from another who allegedly caused the injury or illness, the Covered Person agrees to reimburse the Plan in full for any medical expenses paid by the Plan.

## USING SHP PROVIDER NETWORKS

The choice is yours. When you are ill or injured, you decide where to go for your care. The SHP is a preferred provider organization (PPO). It has arrangements with doctors, hospitals, ambulatory surgical centers and mammography testing centers that have agreed, as part of our networks, to accept the plan's allowable charges for covered medical services as payment in full and will not balance bill you.

If your physician sends your laboratory tests to an out-of-network provider, you may be subject to additional expenses.

This applies to your medical benefits only. Prescription drug and mental health and substance abuse benefits are only paid if you use a network provider.

## How to Find a Medical Network Provider

A State Health Plan Provider Directory is published every January. However, the most up-to-date list of network providers is on the Internet. Go to EIP's Web site, [www.eip.sc.gov](http://www.eip.sc.gov). Choose your category and then select "Online Directories." Choose "State Health Plan Doctors/Hospital Finder." At the site, you will find a list of network providers who will care for you when you need any of these specialties:

- Allergy
- Anesthesiology
- Cardiology (heart and blood vessels)
- Chiropractic
- CNM (Certified Nurse Midwife)
- CRNA (nurse anesthetist)
- Dermatology (skin )
- Endocrinology (hormone-gland)
- Family Practice
- General Practice
- General Surgery
- Geriatrics (the elderly)
- Gynecology (women's reproductive health)
- Internal Medicine (non-surgical diseases in adults)
- Laboratory
- Nephrology (kidney disease)
- Neurological Surgery (nervous system and brain surgery)
- Neurology (nervous system)
- Nurse Practitioner
- OB/GYN (women's reproductive health and child bearing)
- Obstetric (child bearing)
- Oncology (cancer)
- Ophthalmology (eye diseases)
- Optometry (measuring and treating vision problems)
- Oral Surgery (mouth surgery)
- Orthopedic Surgery (bone surgery)
- Otolaryngology (ear, nose and throat)
- Pathology (examination of body tissue and fluids)
- Pediatrics (treatment of children)
- Plastic Surgery (reconstruction of tissue and bone)
- Podiatry (feet)
- Proctology (rectum)
- Pulmonary Disease (lungs)
- Radiology (X-ray)
- Rheumatology (joints and muscles)
- Thoracic Surgery (chest)
- Urology (bladder, kidney and urinary tract)

Printed copies of the provider directories are available from your benefits office or, if you are a retiree, survivor or COBRA participant, from EIP.

**BLUECARD WORLDWIDE®**

When you need medical care **outside South Carolina**, you have access to doctors and hospitals throughout the United States and around the world through the BlueCard Program and BlueCross BlueShield provider networks. If you need mental health or substance abuse care outside South Carolina, please call APS Healthcare at 800-221-8699.

**Inside the U.S.**

With the BlueCard program you can choose the doctors and hospitals that best suit you and your family. Follow these steps for health coverage when you are away from home, but within the United States:

1. Always carry your SHP ID card.
2. In an emergency, go directly to the nearest hospital.
3. To find the names and addresses of nearby doctors and hospitals, visit the BlueCard Doctor and Hospital Finder Web site ([www.BCBS.com](http://www.BCBS.com)) or call BlueCard Access at 800-810-2583.
4. Call Medi-Call for pre-authorization within 48 hours, if necessary. The toll-free number is on your SHP ID card.
5. When you arrive at the participating doctor's office or hospital, show your SHP ID card. As a BlueCard program member, the doctor will recognize the logo, which will ensure that you will get the highest level of benefits with no balance billing.

After you receive care, you should not have to complete any claim forms, nor should you have to pay up front for medical services other than the usual out-of-pocket expenses (deductibles, copayments, coinsurance and non-covered services). You will be mailed an explanation of benefits by BlueCross BlueShield of South Carolina.

**Outside the U.S.**

Through the BlueCard Worldwide® program, your State Health Plan ID card gives you access to doctors and hospitals in more than 200 countries and territories around the world and to a broad range of medical assistance services.

To take advantage of the BlueCard Worldwide® program, please follow these steps:

1. Always carry your current SHP ID card.
2. In an emergency, go directly to the nearest hospital.
3. Before your trip:
  - Call the phone number on the back of your ID card to check your benefit with the State Health Plan and for pre-authorization, if necessary. (Your healthcare benefits may be different outside the U.S.)
  - Call the BlueCard Worldwide® Service Center toll-free at 800-810-2583 or collect at 804-673-1177 to find providers in the area where you will be traveling.
4. During your trip:
  - If you need to locate a doctor or hospital or need medical assistance, call the BlueCard Worldwide® Service Center toll-free at 800-810-2583 or collect at 804-673-1177 (24 hours a day, seven days a week).
  - If you are admitted to the hospital, call the BlueCard Worldwide® Service Center toll-free at 800-810-2583 or collect at 804-673-1177.
  - The BlueCard Worldwide® Service Center will work with the State Health Plan to arrange direct billing with the hospital for your inpatient stay.
  - When direct billing is arranged, you are responsible for the out-of-pocket expenses (non-covered services, deductible, copayment, and coinsurance) you normally pay. The hospital will submit your claim on your behalf.
  - Note: If direct billing is not arranged between the hospital and your plan, you will need to pay the bill upfront and file a claim.
5. For outpatient care and doctor visits, you will need to pay the provider up front and file a claim.
6. To file a claim for services you have paid for up front or paid to providers that are not part of the BlueCard

**Looking for a provider that participates in your network?**

Log onto the EIP Web site at [www.eip.sc.gov](http://www.eip.sc.gov), choose your category and click on "Online Directories." From the "Online Directories" page, you can access participating provider lists for the State Health Plan, Dental Plus and the HMOs (including pharmacy and mental health networks).

Worldwide® network, complete a BlueCard Worldwide® international claim form and send it with the bill(s) to the BlueCard Worldwide® Service Center. The claim form is available online at [www.bcbs.com](http://www.bcbs.com), or by calling the BlueCard Worldwide® Service Center toll-free at 800-810-2583 or collect at 804-673-1177. The address of the service center is on the claim form.

### A Note to Retirees

Remember that the Medicare Supplemental Plan follows Medicare rules. Since Medicare does not provide coverage outside the U.S. Territories, BlueCard Worldwide® coverage **is not** available to the Medicare Supplemental Plan subscribers.

### Prescription Drug and Mental Health/Substance Abuse Provider Networks

Since the SHP offers no out-of-network coverage for prescription drugs or mental health/substance abuse care, it is important that you find a participating network provider for these services. The most up-to-date lists of network providers are on Web sites sponsored by Medco, the prescription drug benefit administrator, and APS Healthcare, Inc., the mental health and substance abuse administrator. These sites are accessible through the EIP Web site, [www.eip.sc.gov](http://www.eip.sc.gov). Choose your category and then select “Online Directories.” You will see a list of links to provider directories. You can also go there directly:

- To see the list of network pharmacies, go to: [www.medco.com](http://www.medco.com).
- Mental health and substance abuse providers include: psychiatrists, clinical psychologists, masters-level therapists and nurse practitioners. To see the list, go to the APS Healthcare, Inc., Web site at [www.apshealthcare.com](http://www.apshealthcare.com). Choose “Commercial Clients” in the top menu bar then “State of South Carolina” from the drop-down menu. Then click on “Online Provider Locator.” The access code is “statesc.” You also may call APS Healthcare toll-free at 800-221-8699 to be directed to a network provider and to receive the required pre-authorization.

For more information on your prescription drug benefits, see page 39. For more information on your mental health and substance abuse benefits, see page 42.

If you do not have access to the Internet, paper copies of the provider directories are available from your benefits office or, if you are a retiree, survivor or COBRA participant, from EIP.

### Out-of-network Benefits for Medical Care

Remember, there is no out-of-network coverage for **prescription drugs**. For **mental health and substance abuse care**, there is no coverage if you use an out-of-network provider or if you fail to have services pre-authorized.

You can use providers who are not part of the network and still receive some coverage for **medical care**. When you do this, you will pay a larger portion of the bill, and you also will fill out the claims forms.

### Balance Billing

If you use a non-network provider, you may be subject to “balance billing.” When the State Health Plan is your primary coverage, network providers are prohibited from billing you for covered services except for copays, coinsurance, and deductibles. However, a non-network provider may choose to bill you for more than the plan’s maximum allowance for the covered service. The difference between what the non-network provider charges and the allowed charge is called the “balance bill.” The balance bill does not contribute to your out-of-pocket maximum.

## OUT-OF-NETWORK DIFFERENTIAL

In addition to balance billing, if you choose a provider that does not participate in the State Health Plan or Blue-Card network, you will pay 40 percent, instead of the usual 20 percent, in coinsurance.

This example shows how you save money using a network provider:

You have employee-only coverage under the SHP. You have received no other medical care during the year, so you have not met your deductible. The non-network provider charges \$5,000 for the covered services you receive, but the SHP maximum allowance is \$4,000.

### Standard Plan

For an individual covered under the Standard Plan using a network provider: You pay the provider \$350, which is applied to your deductible. Then \$3,650 remains of the Standard Plan responsibility. The plan pays 80 percent of that, \$2,920. The remaining \$730 coinsurance is your responsibility, and it is applied toward your \$2,000 coinsurance maximum.

\$4,000	SHP allowance	\$3,650	Standard Plan responsibility
- 350	Standard Plan deductible for 2006	- 2,920	Standard Plan pays
\$3,650	Standard Plan responsibility	730	You pay as coinsurance
x 80%	Standard Plan coinsurance	+ 350	Your Standard Plan deductible
\$2,920	Standard Plan pays	\$1,080	Your out-of-pocket expenses for the services of a network provider.

If you had used a non-network provider for the same services: You pay the \$350 Standard Plan deductible. Then \$3,650 remains of the Standard Plan responsibility. The plan pays 60 percent of that, \$2,190. The remaining \$1,460 coinsurance and the \$1,000 “balance billing” from the non-network provider are your responsibility. There is a \$4,000 coinsurance maximum when you use a non-network provider under the Standard Plan, so the \$1,460 is applied towards your coinsurance maximum.

\$4,000	SHP allowance	\$3,650	Standard Plan responsibility
- 350	Standard Plan deductible for 2006	- 2,190	Standard Plan pays
\$3,650	Standard Plan responsibility	1,460	You pay as coinsurance
x 60%	Standard Plan coinsurance	1,000	Your balance bill from provider
\$2,190	Standard Plan pays	+ 350	Your Standard Plan deductible
		\$2,810	Your out-of-pocket expenses for the services of a non-network provider.

Standard Plan subscribers also pay any per-occurrence deductibles (which do not apply toward your annual deductible) both in-network and out-of-network. They are not included in this example.

## Savings Plan

For an individual covered under the Savings Plan using a network provider: You pay the provider \$3,000, which is applied to your deductible. Then \$1,000 remains of the Savings Plan responsibility. The plan pays 80 percent of that, \$800. The remaining \$200 coinsurance is your responsibility and is applied toward your \$2,000 coinsurance maximum.

\$4,000	SHP allowance	\$1,000	Savings Plan responsibility
<u>- 3,000</u>	Savings Plan deductible for 2006	<u>- 800</u>	Savings Plan pays
\$1,000	Savings Plan responsibility	200	You pay as coinsurance
<u>x 80%</u>	Savings Plan coinsurance	<u>+3,000</u>	Your Savings Plan deductible
\$ 800	Savings Plan pays	\$3,200	Your out-of-pocket expenses for the services of a network provider.

If you had used a non-network provider for the same services: You pay the \$3,000 Savings Plan deductible. Then \$1,000 remains of the Savings Plan responsibility. The plan pays 60 percent of that, or \$600. The remaining \$400 coinsurance, as well as the \$1,000 “balance billing” from the non-network provider, is your responsibility. There is a \$4,000 coinsurance maximum when you use a non-network provider under the Savings Plan, so the \$400 is applied toward your coinsurance maximum.

\$4,000	SHP allowance	\$1,000	Savings Plan responsibility
<u>- 3,000</u>	Savings Plan deductible for 2006	<u>- 600</u>	Savings Plan pays
\$1,000	Savings Plan responsibility	400	You pay as coinsurance
<u>x 60%</u>	Savings Plan coinsurance	1,000	Your balance bill from provider
\$ 600	Savings Plan pays	<u>+3,000</u>	Your Savings Plan deductible
		\$4,400	Your out-of-pocket expenses for the services of a non-network provider.

## MANAGING YOUR MEDICAL CARE

### MEDI-CALL

Some State Health Plan benefits require approval before you receive them. A phone call gets things started. While your healthcare provider may make the call for you, it is your responsibility to call for authorization.

You can reach Medi-Call by phone from 8:30 a.m. to 5 p.m. Monday through Friday. The fax line can be used 24 hours a day. If you do fax information to Medi-Call, provide basic information so the approval process can begin. Be sure to include your name, your identification number, a note about the treatment requiring approval and a telephone number where you can be reached during business hours.

- 800-925-9724 (South Carolina, nationwide, Canada)
- 803-699-3337 (Greater Columbia area)
- 803-264-0183 (fax)

Medi-Call helps you and your covered family members receive appropriate medical care in the most beneficial, cost-effective manner. **Participation in Medi-Call is mandatory whether you are enrolled in the Standard Plan or in the Savings Plan.** You must contact Medi-Call at least 48 hours or two working days, whichever is greater, before receiving these medical services at any medical facility in the United States or Canada:

- You need inpatient care in a hospital<sup>1</sup>
- Your pre-authorized outpatient services result in a hospital admission (You must call again for the hospital admission.)
- You need outpatient surgery for septoplasty, hysterectomy or sclerotherapy
- You need a MRA, MRI or CT Scan

- You will be receiving chemotherapy or radiation therapy
- You are admitted to a hospital in an emergency (Your admission must be reported within 48 hours or the next working day.)<sup>1</sup>
- You are pregnant (You must call within the first three months of your pregnancy.)
- You have an emergency admission during pregnancy<sup>2</sup>
- Your baby is born<sup>2</sup>
- Your baby has complications at birth
- You are admitted to a skilled nursing facility, need home healthcare, hospice care or an alternative treatment program or need durable medical equipment
- You or your covered spouse decides to undergo any In Vitro Fertilization procedure
- You or your covered family member needs to be evaluated for a transplant
- You need inpatient rehabilitative services and related outpatient physical, speech and occupational therapies
- A pre-authorization request for any procedure that may potentially be considered cosmetic in nature must be received in writing by Medi-Call seven days before surgery (i.e., blepharoplasty, reduction mammoplasty, TMJ or other jaw surgery, etc.)

<sup>1</sup>For mental health or substance abuse services, you must call APS Healthcare at 800-221-8699 for pre-authorization before a non-emergency admission or within 24 hours of an emergency admission.

<sup>2</sup>Contacting Medi-Call for the delivery of your baby does not add the baby to your health insurance. You must add your child by filing an NOE within 31 days of birth for benefits to be payable.

Medi-Call approval does not guarantee payment of benefits. Claim payments are still subject to the rules of the plan.

### **Are There Penalties for Not Calling?**

Yes. If you do not call Medi-Call in the required situations, you will pay a \$200 penalty for each hospital or skilled nursing facility **admission**. In addition, the coinsurance maximum will not apply. In other words, you will continue to pay your coinsurance, no matter how much you pay out-of-pocket. If you do not obtain pre-authorization from APS, no mental health or substance abuse benefits will be paid.

## **MATERNITY MANAGEMENT**

Prenatal care is a good way to ensure your health and your baby's health. If you are a mother-to-be, **you must participate in the Maternity Management Program** administered by Medi-Call. You must call Medi-Call during the first trimester (three months) of your pregnancy to pre-authorize your pregnancy benefits. If you do not call Medi-Call during the first trimester, or if you refuse to participate in the Maternity Management Program, you will pay a \$200 penalty for each maternity-related hospital or skilled nursing facility admission. This penalty will be in addition to the Medi-Call pre-authorization penalty, and the \$2,000 coinsurance maximum will not apply.

You are automatically enrolled in the program when you call Medi-Call to pre-authorize your pregnancy. As a participant in the program, you will receive a welcome letter from Medi-Call and a packet of information to which to refer during your pregnancy.

A case management nurse will complete a Maternity Health Assessment form when you enroll. This form is used to identify potential high-risk factors during your first trimester. If high-risk factors are identified, you will be scheduled for follow-up calls. If no risks are identified, you should call with any changes in your condition. Otherwise, you will be sent a reminder card with benefit information during your third trimester.

Also, you can call Medi-Call anytime you have questions. A maternity case management nurse will be there to help you throughout your pregnancy.

## MANAGING FOR TOMORROW®

If you have a chronic condition, such as diabetes, heart disease or asthma, taking care of yourself is a 24-hour-a-day, seven-day-a-week job. Managing your healthcare starts with understanding your condition and your doctor's plan for your treatment.

Managing for Tomorrow® can help. It is available to active employees, retirees who are not eligible for Medicare, spouses and dependents covered by the Standard Plan and the Savings Plan. You may receive a letter or phone call about this unique health management program, which is sponsored by BlueCross BlueShield of South Carolina in cooperation with Prevention Partners.

The program is designed to help you learn more about your condition and ways to improve your health. It is voluntary and free. You will not be asked to purchase anything, your benefits will not be affected and your premiums or copayments will not increase when you participate in Managing for Tomorrow®.

The program starts with an invitation to participate in a confidential survey. The survey helps determine which health education materials are right for you. You will receive a special Personal Identification Number (PIN). This PIN will allow you to complete the survey by calling an automated phone line or by logging on to a secure Web site. Paper surveys also are available.

Everyone who receives an invitation is encouraged to take part in the program. If you think you qualify but have not been invited to participate, call Medi-Call, 699-3337 in the Greater Columbia area, and 800-925-9724 in South Carolina, the U.S. and Canada. Follow the prompts. As a "Member," press 2. Then press 5, the number for "all other inquiries." When you reach an operator, ask to speak with the "Managing for Tomorrow" program.

## COMPLEX CARE MANAGEMENT

Facing a serious illness or injury can be overwhelming, confusing and frustrating. You may not know where to find support or information to help you cope with your illness, and you may not know what treatment options are available.

Complex Care Management can help. It is available to active employees, their spouses and their dependents who are covered by the Standard Plan or the Savings Plan. It is also available to retirees and their spouses and dependents for whom the State Health Plan is primary insurance. This program lets you make informed decisions about your health when you are seriously ill or injured.

The program, offered by BlueCross BlueShield of South Carolina and ParadigmHealth®, Inc., provides you with information and support through a local care coordinator who is a registered nurse. This coordinator acts as an advocate for you and your family. He can help you identify treatment options, locate supplies and equipment recommended by your doctor, coordinate care with your doctor and the SHP, and research the availability of special transportation and lodging for out-of-town treatment.

Participation in the program is voluntary and free. You can leave the program at any time, for any reason. Your benefits will not be affected by your participation in the program.

Here is how the program works: BlueCross BlueShield will refer you to ParadigmHealth® if the program may be of benefit to you. You will receive a letter explaining the program, and a ParadigmHealth® representative will contact you. A care coordinator in your area will visit you to discuss ways he can help you and will ask permission to contact your doctor to offer assistance.

The ParadigmHealth® team, comprised of specially trained nurses and doctors, will review your medical information and treatment plan. (Please note that your medical history and information will always be kept confidential among your caregivers and the ParadigmHealth® team.) Your local care coordinator will be your main program contact. You and your doctor, however, will always make the final decision about your treatment.

By working closely with your doctor and using the resources available in your community, Complex Care Management can help you through a difficult time. If you would like more information on this program, call 800-868-2500. You will reach "Customer Service." Then press 1 and then the extension number, 42648.



More details about Medi-Call can be found on page 30.

Contact Medi-Call at 803-699-3337 (Greater Columbia area) or 800-925-9724 (South Carolina, nationwide and Canada).

## STATE HEALTH PLAN BENEFITS

The Standard Plan and the Savings Plan pay benefits for medically necessary treatments of illnesses and injuries. This section is only a general description of the plan. The *Plan of Benefits* document contains a complete description of the benefits. Its terms and conditions govern all health benefits offered by the state. Contact your benefits administrator or EIP for more information. Some services and treatments require pre-authorization by Medi-Call or APS Healthcare. Be sure to read the Medi-Call section on page 30 and the mental health and substance abuse section on page 42 for details.

### Alternative Treatment Plans

An alternative treatment plan is an individual program to permit treatment in a cost-effective and less intensive manner than is ordinarily required. It requires the approval of the treating physician, BlueCross BlueShield of South Carolina (BCBSSC), Medi-Call and the patient. Services and supplies that are medically necessary because of the approved alternative treatment plan will be covered.

### Ambulance

Ambulance service, to or from a local hospital outpatient department, is covered when used to provide necessary service in connection with an injury or a medical emergency and to or from the nearest hospital providing necessary service in connection with inpatient care. No benefits are payable for ambulance service used for routine, non-emergency transportation, including, but not limited to, travel to a facility for scheduled medical or surgical treatments.

### Contraceptives

For employees and covered spouses, routine contraceptive prescriptions, including birth control pills and injectibles (Depo-Provera and Lunelle), filled at a participating pharmacy or through the plan's prescription mail service, are covered as prescription drugs. Birth control implants and injectibles, given in a doctor's office, are covered as a medical expense.

### Diabetic Supplies

Insulin is allowed under the prescription drug program or under the medical plan but not under both. Since most insulin is brand name, it requires a \$25 copayment for each supply of up to 31 days. Diabetic supplies, including syringes, lancets and test strips, are covered at participating pharmacies for a \$10 copayment, per item, for each supply of up to 31 days. Durable medical equipment, which includes insulin and diabetic supplies, is covered under the SHP. Claims for durable medical equipment should be filed with BlueCross BlueShield of South Carolina.

### Doctor Visits

Charges for treatments or consultations for an injury or illness are covered, as long as they are medically necessary. For mental health and substance abuse services to be covered, you must use a participating provider, and all mental health and substance abuse services must be pre-authorized. For details on mental health and substance abuse services, see page 42.



The SHP Standard Plan has per-occurrence deductibles for some services. See page 23 for details.

## Extended Role Nurse

Expenses for services received from a licensed, independent extended role nurse are covered, even if these services are not performed under the direction of a doctor. An extended role nurse is a nurse practitioner, certified nurse midwife, certified registered nurse anesthetist or a clinical nurse specialist. All services received must be within the scope of the nurse's license.

## Home Healthcare

The plan covers home healthcare performed by a private or public agency. You cannot receive home healthcare and hospital or skilled nursing care benefits at the same time. Benefits are limited to \$5,000 or 100 visits per year, whichever is less. These services must be approved by Medi-Call.

## Hospice Care

The plan will pay benefits for a terminally ill patient's hospice care. The maximum benefit is \$6,000 per covered person, including a maximum of \$200 for bereavement counseling. These services must be approved by Medi-Call.

## Infertility

The plan will pay for diagnosis and treatment of infertility under these conditions: maximum lifetime benefits are \$15,000 incurred by either the subscriber or the covered spouse, whether covered as a dependent or as an employee; a maximum of three completed cycles of gamete or zygote intrafallopian transfer (GIFT or ZIFT), or In Vitro Fertilization (IVF), are allowed; benefits are payable at 70 percent of allowable charges. Your share of the expenses does not count toward your coinsurance maximum. All IVF procedures must be approved by Medi-Call.

The plan will not provide infertility benefits to a subscriber who has had a tubal ligation. **Prescription drugs for treatment of infertility are subject to a 30 percent coinsurance payment under both the Savings Plan and the Standard Plan.** This expense does not apply to the \$2,500, per person, copayment maximum under the Standard Plan. It does apply to the Savings Plan deductible. The 70 percent plan payment for prescription drugs for infertility treatments does apply to both plans' \$15,000 maximum lifetime benefit for infertility treatments. Call Medco's Member Services at 800-711-3450 for more information.

## Inpatient Hospital Services

Inpatient hospital care, including room and board, is covered. In addition to normal visits by your physician while you are in the hospital, you are covered for one consultation per consulting physician for each inpatient hospital stay.

## Organ Transplants

SHP transplant contracting arrangements include the BlueCross BlueShield Association (BCBSA) national transplant network, Blue Quality Centers for Transplants (BQCT). All BQCT facilities meet specific criteria that consider provider qualifications, programs and patient outcomes.

**All transplant services must be approved by Medi-Call (see page 30).** You must call Medi-Call even before you or a covered family member is evaluated for a transplant.

Through the network, BQCT, those covered by the SHP have access to the leading organ transplant facilities in the nation, in addition to the savings the network brings to the plan. Contracts are in effect with several local providers for transplant services so that individuals insured by the plan may continue to use those facilities. If you receive transplant services at one of these network facilities, you will not be balance billed. You will be responsible only for your deductible, coinsurance and any charges not covered by the plan. In addition, these facilities will file all claims for you.

Transplant services at non-participating facilities will be covered by the plan. However, the SHP will pay only the SHP allowed charges for transplants performed at non-network facilities. If you do **not** receive your transplant services at a network facility, you may pay substantially more. In addition to the deductible and coinsurance, subscribers using non-network facilities are responsible for any amount over the allowable charges and will pay an additional 20 percent in coinsurance, totaling 40 percent, because they used out-of-network providers.

Costs for transplant care can vary by hundreds of thousands of dollars. If you choose care outside the network, you cannot be assured that your costs will not exceed those allowed by the plan. Call Medi-Call for more information.

## Outpatient Services

Outpatient laboratory, X-ray, emergency room, radiation therapy, pathology services, outpatient surgery, diagnostic tests and medical supplies are covered. (If the diagnosis is psychiatric, only services provided at APS network facilities are covered.) Some medical laboratories and radiology services are not network providers. If you use the services of a provider that is not in the network, the provider may charge you more than the allowable charge, and you will be billed for the balance.

## Pregnancy and Pediatric Care

Pregnancy benefits are provided to female employees or retirees and the dependent wives of male employees or retirees. **Dependent children do not have maternity benefits.** Maternity benefits include necessary prenatal and postpartum care, including childbirth, miscarriage and complications related to pregnancy. **You must call Medi-Call within the first three months of your pregnancy to enroll in the Maternity Management Program.** See page 31 for more information.

Under federal law, group health plans generally cannot restrict benefits for the length of any hospital stay in connection with childbirth for the mother or the newborn to fewer than 48 hours following normal, vaginal delivery or fewer than 96 hours following a cesarean section. Neither can it require a provider to obtain authorization from the plan for prescribing a length of stay within the above periods. The attending provider, may, however, in consultation with the mother, decide to discharge the mother or newborn earlier.

Pregnancy is not considered a pre-existing condition.

## Prescription Drugs

Prescription drugs, including insulin, are covered subject to plan exclusions and limitations, if you use a participating pharmacy. Drugs in FDA Phase I, II or III testing are not covered. Prescription medications associated with infertility treatments have a different coinsurance rate. Please refer to page 34 for more information.

Nonsedating antihistamines and drugs for treating erectile dysfunction are not covered under the Savings Plan.

## Reconstructive Surgery After Mastectomy

The plan will cover, as required by the Women's Health and Cancer Rights Act of 1998, mastectomy-related services, including:

- Reconstruction of the breast on which the mastectomy has been performed
- Surgery and reconstruction of the other breast to produce a symmetrical appearance
- Prostheses and
- Treatment of physical complications in all stages of mastectomy, including lymph edemas

These services apply only in post-mastectomy cases, and all services must be approved by Medi-Call.

## Rehabilitation

The plan provides limited rehabilitation benefits, subject to the terms and conditions of the plan, including:

- Pre-authorization is required for any inpatient rehabilitation care, regardless of the reason for admission. It

is also required for any outpatient rehabilitation therapy that occurs after inpatient admission for rehabilitation therapy.

- Reasonable expectation that sufficient function can be restored to enable the patient to live outside the hospital setting
- Significant improvement continues to be shown

The plan does not pay benefits for:

- Long-term rehabilitation after the acute phase of treatment for injury or illness
- Vocational rehabilitation
- Pulmonary rehabilitation (except in conjunction with a covered, approved lung transplant)
- Behavior therapy, including speech therapy associated with behavior
- Cognitive (mental) retraining
- Community re-entry programs

## Second Opinion

If Medi-Call advises you to seek a second opinion before a medical procedure, the plan will pay 100 percent of the cost for that opinion. These procedures include surgery as well as treatment (including hospitalization). If APS Healthcare advises you to seek a second opinion before receiving treatment for mental health or substance abuse services, the plan will pay 100 percent of the cost for that opinion.

## Skilled Nursing Facility

The plan will pay limited benefits for room and board in a skilled nursing facility for up to 60 days or \$6,000, based on a per day rate, whichever is less. Physician visits are limited to one per day. These services require approval by Medi-Call.

## Surgery

Physician charges for medically necessary inpatient surgery, outpatient surgery and use of surgical facilities are covered.

## Other Covered Expenses

These expenses are covered if they are determined to be medically necessary:

- Blood and blood plasma
- Nursing services
- Durable medical equipment
- Prosthetic appliances
- Oxygen and rental of oxygen equipment
- Orthopedic braces, crutches, lifts attached to braces and orthopedic shoes
- Dental treatments or surgery to repair damage from an accident, for up to one year from the date of the accident
- Dental surgery for bony, impacted teeth

The plan will pay for extended care as an alternative to hospital care only if it is approved by Medi-Call.

For more information about Prevention Partners, refer to page 15 or log onto the EIP Web site at [www.eip.sc.gov](http://www.eip.sc.gov) and click on "Prevention Partners."

## PREVENTIVE BENEFITS

The Standard Plan and the Savings Plan have benefits that can help make it easier for you and your family to stay healthy. You also are eligible for the Prevention Partners programs described on page 15. By helping prevent potentially expensive health problems and hospital admissions, these benefits help control medical claims costs, saving you and the plan money.

### Mammography Program for Women

Routine, four-view mammograms are covered at 100 percent as long as you use a participating facility and meet eligibility requirements. The State Health Plan does not require a referral from your doctor for a routine mammogram. However, your provider may require one.

- If you are age 35 through 39, one baseline mammogram will be covered during those years.
- If you are age 40 through 49, one routine mammogram every other year will be covered.
- If you are age 50 through 74, one routine mammogram a year will be covered.

Charges for routine mammograms performed at non-participating facilities are not covered, with the exception of procedures performed outside South Carolina. Non-network providers are free to charge you any price for their services, so you may pay more.

For a woman, age 40 and older, covered as a retiree and enrolled in Medicare, Medicare pays for one routine mammogram every year. The SHP is primary for women covered as active employees, regardless of Medicare eligibility.

### Pap Test Program

The plan will pay for a Pap test each year for covered women age 18 through 65. You can receive this benefit whether the Pap test is for routine or diagnostic purposes. The benefit does not include the doctor's visit.

## WELL CHILD CARE BENEFITS

The Standard Plan and the Savings Plan provide coverage for routine checkups and immunizations for children through age 12. Well Child Care benefits are designed to promote good health and aid in the early detection and prevention of illness in children.

### Who is Eligible?

Covered dependent children, from birth through age 12, are eligible for Well Child Care benefits.

### How Does it Work?

This benefit covers regular doctor visits and timely immunizations. When services are received from a doctor in the SHP Physician Network, benefits will be paid at 100 percent without any deductible or coinsurance. **Benefits will not be paid for services from non-network providers.** Some services may not be considered part of the Well Child Care. For example, if during a well child visit a fever and sore throat were discovered, the lab work to verify the diagnosis would not be part of the routine visit. These charges would be subject to deductible and coinsurance, as would any other medical expense.

### Checkups

This is the schedule of regular checkups for which the plan pays 100 percent when a network doctor provides the services:

- younger than 1 year old—five visits
- 1 year old—three visits
- 2 through 5 years old—one visit per year
- 6 through 8 years old—one visit during three-year period
- 9 through 12 years old—one visit during four-year period

## Immunizations

When you use a network doctor, the plan pays 100 percent of the cost for your children's immunizations at the appropriate ages. Below is the recommended schedule. **If your children have not been immunized at these recommended times, please contact your pediatrician or call Medi-Call for instructions on how to get your children properly immunized.**

Disease	Recommended Immunization Schedule
Hepatitis B	Birth - 2 months 1-4 months 6-18 months 11-12 years if not had before
Polio	2 months 4 months 6-18 months 4-6 years
Diphtheria-Tetanus-Pertussis	2 months 4 months 6 months 15-18 months 4-6 years 11-12 years if none in last 5 years
Hemophilus (Hib)	2 months 4 months 6 months 12-15 months
Pneumococcal Conjugate (PCV7)	2 months 4 months 6 months 12-15 months
Measles-Mumps-Rubella	12-15 months 4-6 years 11-12 years if not had second dose before
Chickenpox	12-18 months 11-12 years if not had disease or vaccine before
Influenza	Yearly for healthy children ages 6 months-23 months Yearly for children with risk factors, ages 6 months-12 years
Meningococcal	11-12 years

## Natural Blue

Natural Blue is a discount program available to SHP subscribers. A part of BlueCross BlueShield of South Carolina, it offers holistic healthcare choices and information. The program has a network of licensed acupuncturists, massage therapists and fitness clubs that may be used at lower fees, often as much as a 25 percent discount. Natural Blue also offers discounts on laser vision correction and health products, such as vitamins, herbal supplements, books and tapes. For more on Natural Blue, log on to the Web site at [www.healthyroads.com](http://www.healthyroads.com).

## ADDITIONAL BENEFITS FOR SAVINGS PLAN PARTICIPANTS

As a participant in the Savings Plan, you are taking greater responsibility for your healthcare costs. To make that easier, your plan offers extra preventive benefits at no cost. They include:

- A yearly flu immunization for each eligible participant
- Access to the 24-hour Health at Home<sup>®</sup> Nurseline, through which registered nurses provide personal, immediate assistance to subscribers. The toll-free number is listed on the back of your Health Plan ID card and on the cover of the self-care handbook.
- A copy of the 416-page, full-color self-care handbook, *Health at Home<sup>®</sup>—Your Complete Guide to Symptoms, Solutions & Self-Care*.

Children age 12 and younger receive the Well Child Care benefits and women receive the mammogram and Pap test benefits that are offered to those enrolled in the Standard Plan. In addition, Savings Plan participants age 13 and older may receive from a network provider an annual physical in his office that includes:

- A preventive, comprehensive examination
- A complete urinalysis
- An EKG
- A fecal occult blood test
- A general health laboratory panel blood work
- A lipid panel once every five years

**Note:** If your network physician sends tests to a non-network provider, the tests will not be covered.

## PRESCRIPTION DRUG BENEFITS

### PRESCRIPTION DRUGS – 800-711-3450

Prescription drugs are a major benefit to you and a major part of the cost of our self-insured health plan. Using generic drugs saves you and the plan money. You also can save money, and receive the same FDA-approved drugs, when you refill prescriptions through Medco by Mail, the mail-order prescription service. Remember, benefits are paid only for prescriptions filled at network pharmacies or through the mail service. Prescription drugs, including insulin, are covered subject to plan exclusions and limitations, provided you use a participating pharmacy. Drugs in FDA Phase I, II or III testing are not covered. Prescription medications associated with infertility treatments have a different coinsurance rate. Please refer to page 34 for more information.

### Standard Plan

The prescription drug benefit, administered by Medco, is easy and convenient to use. With this program, you show your SHP identification card when you purchase your prescriptions from a participating retail pharmacy and pay a copayment of \$10 for generic, \$25 for preferred brand or \$40 for non-preferred brand drugs for up to a 31-day supply. If the price of your prescription is less than the copayment, you pay the lesser amount. **Prescription drug benefits are payable without an annual deductible.** There are no claims to file. The prescription drug benefits are the same for the Standard Plan and the Medicare Supplemental Plan.

The prescription drug benefit has a separate annual copayment maximum of \$2,500 per person. This means that after you spend \$2,500 in prescription drug copayments, the Plan will pay 100 percent of your allowable prescription drug expenses for the remainder of the year.

Drug expenses do not count toward your medical annual deductible, coinsurance maximum or your lifetime maximum benefit.

## Savings Plan

With this program, you show your SHP identification card when you purchase your prescriptions from a participating retail pharmacy and pay the full allowable cost of your prescription drugs when you purchase them. There is no copayment.

This cost is transmitted electronically to BlueCross BlueShield of South Carolina. If you have not met your annual deductible, the full allowable cost of the drug will be credited to it. If you have met your deductible, you will be reimbursed for 80 percent of the allowable cost of the drug. The remaining 20 percent of the cost will be credited to your coinsurance maximum.

Nonsedating antihistamines and drugs for erectile dysfunction are not covered under the Savings Plan.

## Generic Drugs

Under both plans, your prescription drug choices are divided into three categories: *generic*, *preferred brand* and *non-preferred brand*.

Generic medications may differ in color, size or shape, but the FDA requires that the active ingredients be the chemical equivalent of the brand-name alternative and have the same strength, purity and quality. Prescriptions filled with generic drugs often have lower allowable costs, under the Savings Plan, and lower copayments, under the Standard Plan. Therefore, you get the same health benefits for less.

You may wish to ask your doctor to mark “substitution permitted” on your prescription. If he does not, your pharmacist will have no choice but to give you the brand-name drug, if that is the way the prescription is written.

## “Pay-the-Difference” Policy

Under the State Health Plan, there is a “pay-the-difference” policy. This means if you purchase a brand-name drug when there is an equivalent generic drug available, the benefit will be limited to that for the generic drug. This policy will apply even if the doctor prescribes the medication as “Dispense As Written” or “Do Not Substitute”.

Under the **Standard Plan**, if you purchase a brand-name drug over a generic, you will be charged the generic copayment, PLUS the difference in price between the brand name and the generic drug. If the total amount is less than the preferred or non-preferred brand copayment, you will pay the brand copayment. Only the copayment for the generic drug will apply toward your copayment maximum.

Under the **Savings Plan**, if you purchase a brand-name drug over a generic, only the allowable cost for the generic drug will apply toward your deductible. After you have met your deductible, only the patient’s 20 percent share of the allowable cost for the generic drug will apply toward your coinsurance maximum.

If you are taking a brand-name drug, you may wish to ask your doctor about using a generic drug, if one is available. If appropriate, the doctor may note on the prescription that substitution is permitted.

## Preferred Brand Drugs

These are medications that Medco’s Pharmacy and Therapeutics Committee has determined to be safe, effective and available at a lower cost than non-preferred brand drugs. A list of preferred brand medications is available online at [www.medco.com](http://www.medco.com). You may reach the Medco Web site through the EIP Web site by clicking on the “Insurance Managers” link.

## Non-Preferred Brand Drugs

These medications are not on the preferred brand list and carry a higher copayment or higher price. All medications that appear on the non-preferred brand list have an effective alternate option either as a generic or as a preferred-brand drug.

## Compounded Prescriptions

A compounded prescription is a prescription that requires the pharmacist to mix two or more ingredients to make the order. It is handled the same way any prescription is handled. It must be purchased from a network pharmacy for benefits to be payable.

Standard Plan subscribers' copayment, which is based on the main ingredient of the compounded prescription, is \$10 for generic, \$25 for preferred brand and \$40 non-preferred brand drug. Savings Plan subscribers pay 100 percent of the allowable charge.

## Pre-authorization

Some medications will be covered by the plan only if they are prescribed for certain uses. These drugs must be authorized in advance, or they will not be covered under the plan. If the prescribed medication must be pre-authorized, you or your pharmacist may begin the review process by contacting Medco at 800-711-3450.

## Retail Pharmacy

You must use a participating pharmacy, and you must show your SHP ID card when purchasing medications. The SHP participates in Rx Selections®, Medco's pharmacy network. Most major pharmacy chains and independent pharmacies participate in this network. A list of participating pharmacies is available online through the EIP Web site, [www.eip.sc.gov](http://www.eip.sc.gov) (Choose your category, then select "Online Directories") or at [www.medco.com](http://www.medco.com).

## MAIL-ORDER PRESCRIPTION SERVICE

The Standard Plan and the Savings Plan offer mail-order service for 90-day supplies of prescriptions. By using this service, you receive a discount on the same FDA-approved prescription drugs that you would buy at a retail pharmacy.

Mail order is an ideal option for anyone with a recurring prescription, such as birth control medicine, or a chronic condition, such as asthma, high cholesterol or high blood pressure.

## Standard Plan

Generic drug copayments are \$25, preferred-brand drug copayments are \$62, and non-preferred brand drug copayments are \$100 for up to a 90-day supply.

## Savings Plan

You pay the full allowable cost when you order prescription drugs through the mail. However, that cost for a 90-day supply will typically be less than you would pay at a retail pharmacy.

## How to Order Drugs by Mail

This is how the mail-order service works:

- Ask your physician to write your prescription for a single 31-day supply and for a 90-day supply with refills.
- Fill your prescription for a 31-day supply at a participating retail pharmacy.
- Complete a mail-order prescription form and mail it to Medco. (Forms are available through the EIP Web site, [www.eip.sc.gov](http://www.eip.sc.gov), under "Forms" or on Medco's Web site: [www.medco.com](http://www.medco.com).)
- Your order will be processed and sent to your home, typically within 10-14 business days. Meanwhile, use your prescription from your retail pharmacy.

Once the initial prescription has been entered and filled, you may order refills online or by phone using Medco's toll-free number: 800-711-3450.



If you have an EZ Reimburse® MasterCard® associated with the MoneyPlu\$ Flexible Spending Account, remember, the card will not work for prescriptions ordered through the mail order pharmacy. For more information on the EZ Reimburse® MasterCard®, see the MoneyPlu\$ chapter, page 123.

If you plan to order a drug by mail, you may wish to check with your doctor or with Medco to make sure a 90-day supply of that specific drug may be sold. In some cases, drugs are limited to less than a 90-day supply because of state law or packaging limitations. If you have questions, call Medco at 800-711-3450.

If you want to save money by ordering a 90-day supply by mail, be sure to ask your doctor to write a prescription for a **90-day supply with refills**. Under the **Standard Plan**, prescriptions written for a 31-day supply with refills will be filled for a 31-day supply, and you will be charged the same copayment that is charged for a 90-day supply. Under the **Savings Plan**, you can buy less than a 90-day supply.

## Coordination of Benefits

The State Health Plan coordinates prescription drug benefits, as well as medical benefits. This ensures that if you are covered by more than one health plan, both plans pay their share of the cost of your care. See page 25 for more information.

## Exclusions

Some prescription drugs are not covered under the plan. See page 44 for more information.

# MENTAL HEALTH AND SUBSTANCE ABUSE BENEFITS

## For Pre-authorization - 800-221-8699

Claims for mental health and substance abuse are subject to the same deductibles, coinsurance and out-of-pocket maximums as medical claims. There are no caps on the number of provider visits allowed as long as the care is medically necessary, and there is not a separate annual and lifetime maximum for mental health and substance abuse benefits.

Here is how the SHP mental health and substance abuse program works:

- When you need care inside or outside South Carolina, call APS Healthcare, Inc., the administrator, at 800-221-8699 to receive pre-authorization and to be directed to a network of providers.
- If you need inpatient care, you must call APS Healthcare for pre-authorization or within 24 hours of an emergency admission.
- The provider network is open, which means that any eligible provider can participate. You may nominate providers for inclusion in the network. If you do not call APS Healthcare or if you choose to use a non-participating provider, no benefits will be paid.
- To review the network of providers, log on to the EIP Web site at [www.eip.sc.gov](http://www.eip.sc.gov), then choose your category and select "Online Directories," or go directly to [www.apshealthcare.com](http://www.apshealthcare.com). Once you are on APS' Web site, click on "Commercial Clients" in the top menu bar. Next select "State of South Carolina" from the drop down list. Then click on "Online Provider Locator." You will need to enter SHP's access code, which is "statesc" (all lower case). Finally, click on "Accept."
- You will then be able to search the directory by either entering a provider's name or a geographic area. If you would like to view or download the directory, go back to the main South Carolina page and click on "Access the Printable Directories," then enter "statesc."

Paper copies of the provider directory are available from your benefits office or, if you are a retiree, survivor or COBRA subscriber, from EIP.

## Free & Clear®

Free & Clear®, an innovative tobacco cessation program, is now available at no charge to State Health Plan subscribers and dependents. It is offered through APS Healthcare.

One of the most successful programs of its kind, it helps participants stop using cigarettes, cigars, pipes and smokeless tobacco. A Free & Clear® tobacco treatment specialist works with each participant to create a personalized "quit plan." As part of the plan, participants receive a Quit Kit and telephone consultations with a tobacco

treatment specialist. The program also provides nicotine replacement products (patches, gum or lozenges) and unlimited access to a toll-free support line. The line is available from 8 a.m. to midnight, seven days a week. Participants who relapse may re-enroll in the program.

To enroll in Free & Clear®, call 1-866-QUIT-4-LIFE (1-866-784-8454). After your eligibility is verified, you will be referred to a tobacco treatment specialist.

### **APS Helplink™**

APS Helplink™ provides tools to help with behavioral health problems, financial and legal issues, child and elder-care concerns and work/life issues. There are two ways to get to APS Helplink.™ The first is to follow the same instructions you use to get to the provider locator, then scroll down the page and follow the instructions for connecting to APS Helplink.™ The second is to go directly to [www.apshelplink.com](http://www.apshelplink.com) and follow these directions:

#### **First-time visitors:**

- At the “First Time Visitor’s” box click on “Sign up”
- If you agree with the disclaimer, click on the “I Agree” button
- Enter “statesc” in the Company Code field
- Enter a user name
- Enter a password
- Re-enter the same password
- Enter a phrase to help you remember your password
- For future reference, write down your user name, password and “statesc”
- Click on the “Submit” button

#### **Returning visitors:**

- Go to the “Returning Visitor’s” box
- Enter “statesc” in the Company Code field
- Enter your user name
- Enter your password
- Click on the “Submit” button

There is no limit to the amount of care you may receive as long as it is authorized as medically necessary. **All services (outpatient office visits, inpatient hospital admissions, etc.) must be pre-authorized by APS Healthcare to be covered.**

There are no claims to file. Your network provider is responsible for submitting claims for these services. **Remember, no benefits will be paid if you receive care from a non-network provider.** Your participating mental health and substance abuse provider will be required to conduct periodic medical necessity reviews (similar to Medi-Call). For claims or customer service assistance for mental health and/or substance abuse care, call APS Healthcare at 800-221-8699.

# Exclusions

## SERVICES NOT COVERED BY THE STATE HEALTH PLAN

There are some medical expenses the State Health Plan does not cover. The *Plan of Benefits* document (available in your benefits office or through EIP) contains a complete list of the exclusions. Some expenses that are not covered are charges for:

- Services or supplies that are not medically necessary and routine procedures not related to the treatment of injury or illness
- Services related to a pre-existing condition in the first 12 months of coverage (or 18 months for late entrants). This may be reduced by any creditable coverage you bring to the plan.
- Routine physical exams, checkups (except Well Child Care and Preventive Screenings according to guidelines), services, surgery (including cosmetic surgery) or supplies that are not medically necessary. (Please note: Under the Savings Plan, an annual physical by a network physician for each participant age 13 and older is covered.)
- Eyeglasses, contact lenses (unless medically necessary after cataract surgery and for the treatment of keratoconus, a corneal disease affecting vision) and routine eye examinations
- Refractive surgery, such as radial keratotomy, and other procedures to alter the refractive properties of the cornea
- Hearing aids and examinations for fitting them
- Dental services, except for removing impacted teeth or treatment within one year of a condition resulting from an accident
- TMJ splints, braces, guards, etc. (Medically necessary surgery for TMJ is covered.) TMJ, temporomandibular joint syndrome, is headache, facial pain and jaw tenderness caused by irregularities in the way joints, ligaments and muscles in the jaw work together.
- Custodial care, including sitters and companions
- Over-the-counter medicine and contraceptive devices
- Services connected with a vasectomy or tubal ligation performed within one year of enrollment
- Surgery to reverse a vasectomy or tubal ligation
- Infertility treatment for subscribers who have had a tubal ligation
- Assisted reproductive technologies (fertility treatment) except as noted on page 34 of this chapter
- Experimental or investigational surgery or medical procedures, supplies, devices or drugs
- Diet treatments and all weight loss surgery, including, but not limited to: gastric bypass or stapling; intestinal bypass and any related procedures; the reversal of such procedures; and conditions and complications as a result of such procedures or treatment
- Equipment that has a non-therapeutic use (such as humidifiers, air conditioners, whirlpools, wigs, artificial hair replacement, vacuum cleaners, home and vehicle modifications, fitness supplies, speech augmentation or communication devices, including computers, etc.)
- Supplies used for participation in athletics (that are not necessary for activities of daily living)
- Physician charges for medicine, drugs, appliances, supplies, blood and blood derivatives, unless approved by the claims administrator
- Medical care by a doctor on the same day or during the same hospital stay in which you have surgery, unless a medical specialist is needed for a condition the surgeon could not treat
- Physician's charges for clinical pathology, defined as services for reading any machine-generated reports or mechanical laboratory tests
- Fees for medical records and claims filing
- Food supplements
- Services performed by members of the insured's immediate family
- Acupuncture
- Chronic pain management programs
- Transcutaneous (through the skin) electrical nerve stimulation (TENS), whose primary purpose is the treatment of pain
- Complications arising from the receipt of non-covered services
- Psychological tests to determine job, occupational or school placement or for educational purposes; milieu

- therapy; or to determine learning disability
- Services or supplies payable by Workers' Compensation or any other governmental or private program (including Employee Assistance Program services)
- Charges for treatment of illness or injury or complications caused by acts of war or military service, injuries received by participating in a riot, insurrection, felony or any illegal occupation (job)
- Intentionally self-inflicted injury that does not result from a medical condition or domestic violence
- Cosmetic goods, procedures or surgery or complications resulting from such procedures or services
- Nicotine patches used in smoking cessation programs, as well as prescribed drugs used to alleviate the effects of nicotine withdrawal, except as authorized for eligible participants enrolled in the Free & Clear<sup>®</sup> tobacco cessation program.
- Vocational rehabilitation, pulmonary rehabilitation (except in conjunction with a covered and approved lung transplant), behavior therapy, including speech therapy associated with behavior, cognitive (mental) retraining, community re-entry programs or long-term rehabilitation after the acute phase of treatment for the injury or illness
- Congenital anomalies (abnormalities existing since birth) are not covered unless the covered person has been continuously covered under the Plan from birth until the time of treatment
- Sclerotherapy (treatment of varicose veins), including injections of sclerosing solutions for varicose veins of the leg, unless a prior-approved ligation (tying off of a blood vessel) or stripping procedure has been performed within three years and documentation establishes that some varicosities (twisted veins) remained after the procedure
- Animals trained to aid the physically challenged
- Abortions, except for an abortion performed in accordance with federal Medicaid guidelines
- Pregnancy of a covered dependent child

#### **Additional exclusions under the Savings Plan:**

- Out-of-network in- or outpatient charges related to the annual physical benefit under the Savings Plan are not covered.
- Chiropractic benefits, under the Savings Plan only, are limited to \$500 per covered person after the annual deductible is met.
- Non-sedating antihistamines and drugs for treating erectile dysfunction are not covered under the Savings Plan.

## **STATE HEALTH PLAN APPEALS**

### **WHAT IF MY CLAIM OR REQUEST FOR PRE-AUTHORIZATION IS DENIED?**

The Employee Insurance Program contracts with claims processors, BlueCross BlueShield of South Carolina, Medco and APS Healthcare, Inc., to handle claims for your State Health Plan benefits. You have the right to appeal their decisions. This is how to do it:

If all or part of your claim or of your request for pre-authorization is denied, you will be informed of the decision promptly and told why it was made. If you have questions about the decision, check the information in this book, or call the company that made the decision for an explanation.

If you are unsure whether the decision was fair, you can ask the company to re-examine its decision. This request should be in writing and should be made within six months after notice of the decision. If you wait too long, the decision will be considered final.

If you are still dissatisfied after the decision is re-examined, you may ask the Employee Insurance Program (EIP) to review the matter by making a written request to EIP within 90 days of notice of the denial. If the denial is upheld by EIP, you have 30 days to seek review in the circuit court pursuant to S.C. Code Ann. 1-23-380 (Law. Co-op. 1986 & Supp. 2001).

